PATIENT ASSISTANCE PROGRAM GRANDFATHERING NOTIFICATION FORM

Plan/Medical Group Name: My Health LA Plan/Medical Group Fax#: 310-669-5609

Instructions: The intent of this document is to notify DHS Central Pharmacy of existing patients who are currently stabilized on a medication through a manufacture Patient Assistance Program (PAP). Please fill out all applicable sections completely and legibly. Attach any additional documentation that relevant, e.g. chart notes or lab data, and forward to Department of Health Services Central Pharmacy for processing VIA FAX 310-669-5609 or email PRIORAUTH@DHS.LACOUNTY.GOV.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	MHLA MRN:	Phone#:

Address:	City:	State:	Zip Code:

DOB:	☐ Male ☐ Female	Height (in/cm): _____ Weight (lb/kg): _____	Allergies:

Patient's Authorized Representative (if applicable):	Authorized Representative Phone#:

Prescriber Information

First Name:	Last Name:	Specialty:

NPI# (individual):	DEA# (if required):	Phone#: Fax#:	Email:

MHLA Clinic ID:	Address:	City:	State:	Zip Code:

PAP Medication

Medication Name:	Manufacturer:	Dose/Strength:	Frequency:	Quantity:

Diagnosis:	Date Initiated:	Duration of Therapy:	Route of Administration: ☐Oral/SL ☐Topical ☐Injection ☐IV ☐Other: _____

Dispenser Contact Information

Phone#: Fax: Email:

Clinical Information

1. Additional Clinical Information – Please provide any other relevant clinical information related to the PAP medication.

☐ See Attachments